October 31, 1997

Honorable Janice R. Lachance
Acting Director
U.S. Office of Personnel Management
Washington, D.C. 20415

Dear Ms. Lachance:

I respectfully submit the Office of the Inspector General's Semiannual Report to Congress for the period April 1, 1997 to September 30, 1997. This report describes our office's activities during the past six-month reporting period.

Should you have any questions about the report or any other matter of concern, please do not hesitate to call upon me for assistance.

Sincerely,

Patrick E. McFarland
Inspector General

Table of Contents

Message From the IG

Since my tenure as Inspector General (IG) began here at the Office of Personnel Management (OPM), the infrequency of our audits of the Federal Employees Health Benefits Program (FEHBP) insurance carriers has been of great concern to me. This concern has been reflected on several occasions in past semiannual reports. Further, this condition has been reported as an agency material weakness under the Federal Managers' Financial Integrity Act (FMFIA). In addition, unaudited data from experience-rated carriers has been consolidated with agency data, which was a contributing factor in the disclaimer of opinion on OPM's health benefit program financial statements. This, too, is of considerable concern to me and to agency management.

A partial solution to these problems has been developed through a quality improvement team (QIT) made up of members of our auditing component along with that of the agency's Retirement and Insurance Service (RIS). Under current program requirements, experience-rated carriers must provide an audited corporate financial statement. These audits are generally conducted in accordance with the normal business practices of the carrier. Under guidelines now being developed by the above-cited QIT, experience-rated carriers will have to expand their respective corporate audits to include an audit of the carrier's FEHBP operations. The audit work will be done by independent public accountants (IPAs) engaged by each insurance carrier. Each IPA will be funded through the FEHBP contract with each carrier.

As stated in the Inspector General Act of 1978 (IG Act), it is the IG's responsibility to take appropriate steps to ensure that any work performed by non-federal auditors complies with the standards established by the Comptroller General of the United States. To assure compliance with government auditing standards and to facilitate the audit work, our office is preparing an audit guide that will set forth the scope of work and other audit requirements. In drafting these requirements, we are focusing the IPAs on their areas of strength; namely, opinions on the financial statement, assessment of internal controls, and the performance of certain work in financial management areas, such as reconciliations, cash management, and accounting for refunds and credits. We do not expect these audits to result directly in significant monetary findings.

The addition of these IPA resources provides our Office of Inspector General (OIG) with new opportunities to expand the scope of our audit activity in the highly vulnerable health insurance area. In future OIG compliance audits, after we obtain assurance of the quality of IPA work, the OIG will rely on the IPAs and not repeat their efforts. Instead, we will focus on those aspects of contract performance where we have program expertise, such as the allowability and allocability of administrative expenses, allowability of benefit payments, and the detection of benefit payment fraud and abuse. Also, the IPA work related to assessing internal controls will help us target

carrier program operations where these controls are weak. By combining the IPA audit reviews with our own, we will be able to expand significantly the level of oversight of FEHBP carrier operations.
As is well known, fraud and abuse in health insurance are widespread. Because of past resource limitations and the need to provide basic audit services, we were not able to devote the time necessary for the detection of fraud and abuse at the medical-provider level. The U.S. General Accounting Office estimates that fraud in health programs represents at least 10 percent of costs. In the FEHBP, this would mean about $1.5 billion annually.

With basic carrier audit services covered by the IPA, we will be able to devote more time to the detection of fraud and abuse by medical providers. In addition, we expect to be able to cover more cross-cutting program issues than we have in the past. For example, routine audits frequently disclose trends or issues that cut across carriers. We will now be able to target those issues for closer scrutiny.

We also will be able to direct more resources to our health carrier rate reconciliation audits (RRAs) that we initiated last year and first reported on in our October 1996 semiannual report. We believe these additional audit resources for RRAs will continue to produce significant monetary savings for the FEHBP. The success of our RRA initiative is discussed in more detail on pages 9-11.

Another important benefit will be our ability to respond more readily to requests for audit services from program managers. In summary, our audit staff will be able to provide more timely and comprehensive support to the agency in its management of the FEHBP.

Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds $22,277,684

Recoveries Through Investigative Actions . . . . . $ 4,647,512

Management Commitments to Recover Funds 32,698,486

Note: OPM management decisions for recovery of funds during this reporting period reflect amounts covering current and past reporting period audit recommendations.

ACCOMPLISHMENTS:

Audit Reports Issued 29

Investigative Cases Closed 27

Cases Accepted for Prosecution 10

Indictments 11

Convictions 11

Hotline Contacts and Complaint Activity 1017

Health Care Provider Debarments and Suspensions 1290

Statutory and Regulatory Review

As is required under section 4 (a)(2) of the Inspector General Act of 1978, as amended, our office monitors and reviews legislative and regulatory proposals for their impact on the Office of the Inspector General (OIG) and Office of Personnel Management (OPM) programs and operations. Specifically, we perform this activity to evaluate their potential for encouraging economy and efficiency and preventing fraud, waste and mismanagement. We also monitor legal issues that have a broad effect on the Inspector General community and present testimony and other communica- tions to Congress as appropriate.

During this reporting period, the administrative sanctions program relating to health care providers under the FEHBP was realigned within the Office of the Inspector General to be placed under the supervision of our special counsel. This reflects the fact that sanctions activities are primarily legal and regulatory in nature.

In addition, we furnished advice and support to OPM in drafting proposed legislation that would afford the agency the same ability to protect FEHBP from improper or fraudulent conduct by health care providers that is available to other federally funded health care programs administered by other government entities. Also during this reporting period, the Inspector General was asked to testify before a House subcommittee regarding investigative practices of OIGs. These activities are described in the following articles.

Legislative Review

IG Testifies on OIG Criminal Investigative Practices

On June 24, 1997, OPM Inspector General Patrick E. McFarland testified before the House Subcommittee on Government Management, Information, and Technology on the subject of criminal investigation practices within Offices of Inspector General. IG McFarland appeared on a panel with four other members of the President's Council on Integrity and Efficiency (PCIE). The subcommittee is chaired by Representative Steve Horn (R-California).

At this oversight hearing, some subcommittee members raised the issue of the constitutional rights and responsibilities of federal employees that frequently arise during the course of an OIG investigation. As a direct response to some specific areas of professional conduct that came into question during the course of this hearing, Inspector General McFarland, as PCIE Investigations Committee chairman, took the initiative to have a pamphlet prepared specifically for federal employees that explains the investigative process in detail and the role of the various parties involved in an OIG investigation. This pamphlet soon will be distributed electronically to

those OIGs associated with a civilian agency or department work force. In turn, these organizations may make the information in this pamphlet available to the employees of their respective departments or agencies as is appropriate.

IG Takes Action to Ensure Quality OIG Investigative Performance

FEHBP Administrative Sanctions Bills Introduced

Two bills were introduced in the U.S. House of Representatives during the reporting period containing substantial portions of legislative language that our office assisted OPM's Office of Congressional Relations in preparing. These were H.R. 1836, the Federal Employees Health Care Protection Act of 1997, and H.R. 1971, the Federal Employees Health Benefits Provider Integrity Amendments of 1997.

Both pieces of legislation would enable our agency to issue debarment orders against health care providers who have acted improperly with regard to the FEHBP after an agency-based proceeding, with the sanction remaining in place during subsequent administrative and judicial appeals.

As we have indicated in prior semiannual reports, procedural impediments to rendering sanctions orders have made the existing FEHBP sanctions law not only unfeasible but cost-prohibitive to operate. While these requirements in general are far more stringent than those applied to other federally funded health care programs, the most problematic aspects involve the proviso that all levels of both administrative and judicial appeal be exhausted before any sanction order can become effective.

In the preceding Congress (104th Congress), H.R. 3841, which contained sanctions provisions similar to those in the current legislation, was approved by voice vote in the House but never received Senate consideration prior to adjournment. Based on our belief that an effective administrative sanctions program is an essential part of a complete health care integrity program, our OIG is working closely with OPM to achieve congressional action on these sanctions bills during this Congress. We have consulted on a continuing basis with members of Congress and various committee and subcommittee staff to provide information on how we would operate a statutorily based sanctions program and the resultant benefits that would accrue to the FEHBP and federal employees. We have also met with private sector groups whose interests may be affected by passage of such legislation.

OIG Directs Efforts Toward Passage of Health Care Sanctions Legislation

Administrative Sanctions Update

Pending enactment of legislation with administrative sanctions provisions, such as those referenced in the prior article (H.R. 1836 or H.R. 1971), OPM has no workable statutory vehicle for taking direct action against health care providers who act improperly or illegally against the FEHBP. However, to partially mitigate this resultant vulnerability, our office has continued to use the government-wide regulatory program established under the nonprocurement debarment and suspension common rule (common rule) to debar from participation in the FEHBP any health care provider who has been the subject of prior sanctions by another federal health care program, such as Medicare. These "common rule" actions, however, do have significant shortcomings, including the fact that they do not permit civil monetary actions to recover funds improperly paid, nor can they be used to sanction providers who have been identified with FEHBP fraud unless there was an existing sanction from another federal agency.

During the reporting period, we issued 1,290 common rule debarments, which is a 216 percent increase over the last period. In addition, our office increased its efforts to ensure that FEHBP carriers are implementing debarment orders effectively by working with the OIG's Office of Audits to develop on-site review procedures of the carriers' sanctions activities relating to debarred health care providers.

OIG Issues 1,290 Debarments Under "Common Rule" Sanctions Program

Audit Activities

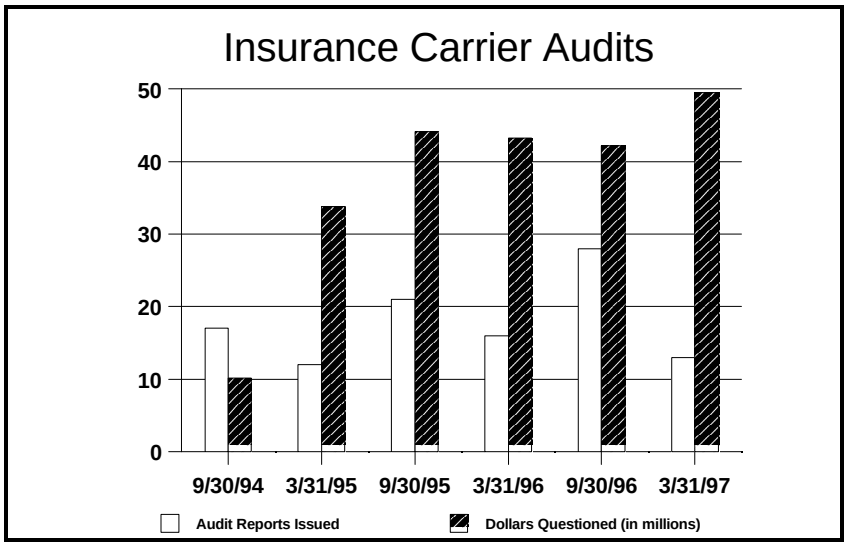
Health and Life Insurance Carrier Audits

The Office of Personnel Management contracts with private sector firms to underwrite and provide health and life insurance benefits to federal employees, annuitants, and their dependents and survivors through the Federal Employees Health Benefits Program and the Federal Employees' Group Life Insurance Program. Our Office of Inspector General is responsible for auditing their activities.

Our audit universe contains approximately 565 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations, as well as two life insurance carriers, all of which share in annual premium payments in excess of $16.5 billion.

During the current reporting period, we issued 26 final reports on organizations participating in the FEHBP, 21 of which contain recommendations for monetary adjustment in the aggre- gate amount of $22.3 million due the FEHBP. Five of the reports did not contain any recommendation for monetary adjustment. Of the 26 reports issued, 18 were for rate reconciliation audits, which are referenced in an article on pages 9-11 of this section. A complete listing of all these reports is provided in Appendices III-A and III-B on pages 42-45 of this report.

We believe it is important to illustrate the dollar significance resulting from our audits of FEHBP carriers and what this means to the FEHBP trust fund. For instance, during the past six semiannual reporting periods, the OIG issued 107 reports and questioned $223 million in inappropriate FEHBP charges as the graph below illustrates.



The sections that immediately follow explain the differences among the types of FEHBP carriers and provide audit summaries of significant final reports we issued during the past six months.

Community-Rated Plans

Within the community-rated, comprehensive medical plans, also known as health maintenance organizations (HMOs), we audit approximately 450 rating areas. A community- rated carrier generally sets the subscription rates for benefits on the basis of an average revenue requirement for each member. Under current statutes for HMOs, subscription rates can vary from group to group as the result of adjustments for factors such as the age and sex distribution of a group's enrollees (community rating by class) or its projected utilization of benefits (adjusted community rating). However, once a rate is set, it may not be adjusted to actual costs incurred or actual utilization. The inability to adjust to actual costs or utilization distinguishes community-rated plans from experience-rated HMOs, indemnity, or service benefit plans.

Prior to 1991, all community-rated carriers were required to submit a certificate of community rating, certifying that the rates offered to OPM were in fact the community rates being offered to all groups, adjusted for benefit differences. OIG's audits of community- rated plans were designed to verify that the community rates certified to OPM were being consistently charged to **all** groups. If an audit disclosed that the carrier had offered some groups rates lower than the community rates, then a condition of defective community rating (DCR) was deemed to exist. OPM regulations and FEHBP contract clauses provided that OPM was entitled to a downward rate adjustment. This adjustment reflected the fact that, as a result of accepting community-rating principles, OPM had given up the right to negotiate rates on a competitive basis.

In 1991, OPM revised its regulations to require that subscription rates charged to the FEHBP be equivalent to the rates charged those two subscriber groups closest in size to the FEHBP and whose respective contracts contain similar benefits. These similarly sized subscriber groups are called SSSGs. Under these regulations, each carrier must certify that the FEHBP is being offered equivalent SSSG rates by submitting to OPM a certificate of accurate pricing. These rates are determined by the FEHBP-participating carrier, which has the responsibility of selecting the two groups that qualify as SSSGs. During an audit, should our auditors determine that equivalent rates were not applied to the FEHBP or that the appropriate SSSGs were not selected, then a condition of defective pricing (DP) exists. The FEHBP is entitled to a downward rate adjustment to compensate for any overcharges resulting from DP.

During this reporting period, we issued 23 audit reports on community-rated plans. The following summaries of two HMO audits issued during the current period illustrate a number of problems encountered in applying and enforcing community-rating principles within the FEHBP.

HMSA Community Health Program in Honolulu, Hawaii

Report No. F6-00-95-018

April 15, 1997

Our office performed an audit of HMSA Community Health Program (HMSA) for contract years 1990 through 1994. Our previous audit of the plan was completed in 1987 and covered contract years 1983 through 1987. HMSA, based in Honolulu, Hawaii, entered the FEHBP in 1979 as a community-rated comprehensive health plan. During this time, it has been providing primary health care services to plan members throughout the state of Hawaii, with the FEHBP being the plan's single largest group, comprising approximately 80 percent of the plan's total member enrollment. From 1990 through 1994, the FEHBP paid premiums to HMSA totaling over $16.7 million.

We examined HMSA's federal rate submissions and related documents to verify whether the plan had offered community rates or market price rates to the FEHBP as agreed to under the terms of its contract for the years audited. Our auditors also looked at the loadings (contract charges and credits, also known as riders) to FEHBP's rates to determine if these were reasonable and equitable. We found that the premium rates set by HMSA for contract year 1990 did comply with OPM regulations but not those for contract years 1991-1994, resulting in overcharges to the FEHBP in all years except 1993. Our review disclosed that HMSA had undercharged the FEHBP in 1993 in the amount of $63,462 due to a flawed rating methodology used by the plan.

After applying the appropriate defective pricing remedy for those years that the plan was in violation of its certificates of accurate pricing filed with our agency, and taking into account undercharges to the FEHBP in 1993 as cited above, the net amount due the FEHBP was $1,202,431. The latter amount also included $246,265 for lost investment income for the years 1991 through 1996. The FEHBP also is entitled to additional lost investment income for the period beginning January 1, 1997, until all funds due the FEHBP have been returned.

Auditors Determine $1,202,431 Due the FEHBP Trust Fund

Premium Rates and Loadings

As previously noted, our examination of premium rates in 1990 showed that the plan's rates to the FEHBP were reasonable and equitable. In addition, our review of the special benefits loadings for that year indicated that HMSA had understated its medical/surgical benefits credit by $5,237 and was therefore due this amount. In the remaining contract years we audited, however, we determined that the plan's certificates of accurate pricing were defective due to rating inconsistencies between the FEHBP and other commercial groups selected as SSSGs. Also, in contract years 1992 and 1994, we determined that HMSA offered rate concessions to the SSSGs

that were not offered to the FEHBP. As a consequence, our auditors calculated the amounts due the FEHBP as follows: $314,135 in 1991; $194,609 in 1992; and $516,301 in 1994.

The plan agreed with our monetary findings in 1992 and 1993, along with the fact that the FEHBP's rates were developed from a different methodology than that used for the SSSGs for the contract years under review in this audit. However, it maintained that the FEHBP was not due additional monies simply because of differences in the rating methodologies. For example, the plan disagreed with our recommended 1991 audit adjustment, stating that the 1991 overcharge should be allowed based on documentation it sent to OPM when the rates were set, which did show that different rating methodologies were being used to rate the FEHBP and SSSGs. With respect to 1994, HMSA has stated that it wants to review the information on the discount given one of the SSSGs before making a decision on any amounts due for that year. We continue to disagree with HMSA's position and have recommended that OPM's contracting officer require HMSA to return all the amounts we cited as overcharges in our monetary findings.

Internal Controls

We reviewed the plan's rating guidelines and met with HMSA officials to determine if its rating system had adequate internal controls. Our review showed several problems that we considered weaknesses in its rate setting system and which, therefore, could have a detrimental impact on the FEHBP, as shown through our findings.

One such internal control deficiency related to the fact that the plan did not have written underwriting policies. Further, we learned that the statistics manager was responsible for the FEHBP rate submissions and determining if the FEHBP was receiving the market price rate. On the other hand, the underwriting department was responsible for developing the rates for all other groups, including the SSSGs. Not only did our review reveal that the underwriting department operated without any written policies regarding rate development, but the rates developed did not seem to bear any consistency from one subscriber group to another. HMSA agreed with our recommendation to centralize all rating activities within the underwriting department, to document its rating guidelines, and to review and update its policies annually as necessary.

Auditors Recommend Tightening Internal Controls for Rating System

Lifeguard, Inc.
in Milpitas, California

Report No. CD-00-95-005

April 10, 1997

This community-rated comprehensive medical plan operates as an individual practice plan, meaning that choices are given to members much the same way as under the preferred provider option given to subscribers in a fee-for-service plan. Our audit of Lifeguard, Inc. (Lifeguard) was performed at its headquarters in Milpitas, California, and covered contract years 1990-1994. This plan offers primary health care services to its members throughout the Northern California Bay area, with the FEHBP comprising one of its largest groups. For the five-year period we reviewed, the FEHBP paid premiums to Lifeguard totaling $36 million.

To verify whether Lifeguard offered community rates or market price rates to the FEHBP, we examined Lifeguard's federal rate submissions to OPM and other related documents. Our auditors also looked at the plan's rate development documentation and billings for other subscriber groups. Our review showed that Lifeguard's rating of the FEHBP in 1991 and 1993 was properly determined in accordance with OPM's regulations and instructions. However, insofar as the other contract years were concerned, we found that defective rating and pricing did occur, thus placing the plan in violation of its certificate of community rating for 1990 and its certificate of accurate pricing for 1992 and 1994.
It also should be noted that in the last audit of this plan completed in 1989, covering contract years 1985-1989, we also determined that a defective community-rating condition existed.

Regarding the current audit, the total amount of overcharges to the FEHBP was $1,041,483, including an assessment of $143,673 for lost investment income experienced by the FEHBP on the questioned amounts.

Defective Rating and Pricing Overcharges Cost FEHBP $1,041,483

Premium Rates

As previously stated, in 1991 and 1993, Lifeguard's rating of the FEHBP was properly determined in accordance with OPM's regulations and instructions. However, in 1990, our audit disclosed a defective community rating finding, because the plan gave a discount to an SSSG that was not offered to the FEHBP. To correct this DCR condition, we reduced the FEHBP's rates by the amount of the discount offered to the SSSG (0.7 percent). We calculated the overcharge to the FEHBP at $42,202. The plan had no comment on this finding.

In its 1992 rate reconciliation, the plan chose an SSSG that we later determined did not meet the criteria to be an SSSG. We noted that another group was actually closer in size to the FEHBP and had been given a rate advantage of 5.5 percent. Accordingly, we reduced the FEHBP's 1992 rates by that rate advantage and determined that the plan overcharged the FEHBP in the amount of $433,781. The plan objected not only to our SSSG selection but to the calculations we used to determine the amount of the overcharge to the FEHBP.

Lifeguard based its objections on the fact that the SSSG we designated was incorrect, reasoning that the group we cited had purchased a different basic benefit package and had different copayment rates than the FEHBP, thus making it ineligible as an SSSG. Lifeguard also insisted that simply providing a discount to an SSSG not offered to the FEHBP did not necessarily trigger a defective pricing situation under the terms of its FEHBP contract. In addition, the plan stated that our methodology for calculating a DP remedy was wrong. After reviewing each of these contentions, we were unable to agree with Lifeguard on any of its key positions except to lower the downward adjustment rate from 5.6 to 5.5 percent for 1992.

In regard to the 1994 rates set by Lifeguard, the plan derived its rates for groups other than the FEHBP using a new methodology totally dissimilar from that used for the FEHBP's rates. Lifeguard stated it did this deliberately so that the FEHBP would not be subject to excessively high and uncompetitive rates. We noted that the plan did not have written procedures on exactly how this new rating methodology would operate and did not furnish our auditors with a detailed model as requested.

Our auditors also noted that Lifeguard was inconsistent in its rating of the two SSSGs under this new methodology and that rate calculations for both groups contained critical data that the plan could not support. To remedy the discrepancy in the FEHBP rates, we established that the FEHBP was due a downward adjustment of $421,827.

Rating Inconsistencies Result in $897,810 Loss to FEHBP

Lost Investment Income

In accordance with the FEHBP contract for community-rated plans, we calculated an assessment for lost investment income of $143,673 on the defective pricing findings in 1992 and 1994. We have requested that the OPM contracting officer have this amount returned to the FEHBP trust fund along with any additional interest amounts accruing, beginning January 1, 1996, until such time as the plan has returned all monies related to our findings owed the FEHBP.

Lost Investment Income to FEHBP Totals $143,673

HMO Rate Reconciliation Audits

In our semiannual report to Congress for the period of April 1 through September 30, 1996, we highlighted a new audit approach for FEHBP's community-rated carriers which supplements our standard community-rated audits. The pilot test of ten rate reconciliation audits was highly successful, receiving enthusiastic praise from OPM contracting officials, who specifically requested that we continue these types of audits.

Due to this early success, we scheduled and completed 18 RRAs in fiscal year 1997.

As a result of these audits, we recommended premium rate changes for 14 carriers. Total questioned costs for 11 of these audits amounted to $12.8 million. For the other three audits, we found that the FEHBP owed the plans a total of $290,000. OPM contracting officials negotiated savings on these audits of $10 million.

Our standard community-rated audits are done on a post-award basis, usually several years after the completion of the contract year. The RRAs differ in that they are performed prior to final rate settlement, which is done when contract rates based on estimated community rates are reconciled to actual community rates.

RRAs Yield $10 Million in Savings to FEHBP

The RRA concept was designed to assist OPM contracting officials in negotiating the best premium rates possible by ensuring that they have been provided with current, complete and accurate information by participating community-rated HMOs. To accomplish this, RRAs are limited to only the current year's rate reconciliation and must be performed and completed from mid-May through very early August. This time frame coincides with the period OPM's Office of Actuaries actually receives the rate reconciliation and finalizes the entire rating process. Annual rate reconciliations allow the carriers to adjust their estimated community rates to the rates that are actually in effect for the current contract year.

The goal of the RRA process is to start and complete the audits, including the issuance of a report to OPM contracting officials, in about a six-week period. During the process, our audit staff is in continuous communication with representatives of OPM's Office of Actuaries. By working as a team, premium rates can be negotiated and finalized in an efficient and timely manner.

Our audit results have shown that rate reconciliation audits provide significant benefits to OPM and participating community-rated carriers in the following ways:

- Auditors are reviewing data shortly after it is produced; therefore, records and carrier staff familiar with the records should be readily available to assist in both the audit and resolution of any audit issues.

- Representatives from OPM's Office of Actuaries, as well as the insurance plans, receive almost immediate feedback relating to the audit results.

- The audit resolution process begins immediately, thus benefiting both the insurance plans and OPM through timely resolution of audit issues.

- RRAs result in more timely and more frequent audit coverage of the universe of HMOs that participate as community-rated carriers.

- The RRAs reduce the uncertainty of future carrier liabilities that would otherwise result from a post-award audit and will avoid interest accruals.

The results of this current round of RRAs is consistent with our pilot results. For example, our audit of The George Washington University Health Plan's (GWU plan) proposed rates disclosed that one of the two SSSGs received a 7.3 percent discount, while the FEHBP only received a 4.5 percent discount in the plan's reconciliation. In accordance with the contract and federal regulations, the FEHBP is entitled to the larger of any premium rate discount offered to either of the SSSGs. Thus, the FEHBP is entitled to an additional
2.8 percent discount. In addition, the plan included chiropractic and mental health loadings that were not in the proposal and excluded a tax credit that was in the proposal. In total, the FEHBP was due a rate reduction of $3,249,472 from the GWU plan. During the rate negotiation process, the OPM contracting officials were able to negotiate a rate reduction of $3,227,971, a difference of only $21,501 from our original recommendation.
Based on the results of the fiscal years 1996 and 1997 RRAs, this new and innovative audit methodology has proven to be an impressive tool in carrying out the OIG's responsi- bility of providing effective and efficient oversight of the FEHBP. We have again incorporated this audit strategy into our FY 1998 audit plans.

Experience-Rated Plans

In addition to community-rated plans, the FEHBP offers a variety of experience-rated plans, including the Government-wide Service Benefit Plan, those plans sponsored by employee organizations, and comprehensive medical plans (experience-rated HMOs). An experience rate is a rate that reflects a given group's projected paid claims, administrative expenses, and retentions. Each carrier maintains separate accounts for its federal contract, and future premiums are adjusted to reflect the federal enrollees' actual past use of benefits.

Audits of these plans generally focus on the allowability of contract charges and the recovery of appropriate credits, the effectiveness of carriers' claims adjudication systems, and the adequacy of internal controls to ensure proper contract charges and benefit payments.

Government-Wide Service Benefit Plan

This plan is administered by the Blue Cross and Blue Shield (BCBS) Association on behalf of its member plans. The association delegates authority to participating local Blue Cross and Blue Shield plans throughout the United States to underwrite and process the health benefits claims of its federal subscribers in the Service Benefit Plan. For administrative purposes, the association has established a Federal Employees' Program (FEP) Director's Office in Washington, D.C., that provides centralized management for the Service Benefit Plan, including a claims control center. This office, known as the FEP Operations Center, verifies, among other things, subscribers eligibility; approves or disapproves the reimbursement of local plan payments of FEHBP claims (using computerized system edits); and maintains both

a history file of all FEHBP claims and an accounting of all program funds.

The BCBS federal employee program currently consists of approximately 60 audit sites throughout the United States. Approximately 40 percent of all FEHBP subscribers are enrolled in Blue Cross and Blue Shield plans nationwide.

During this reporting period, we issued one BCBS report. The following audit summary describes the major findings from that report, along with the questioned costs associated with those findings.

Blue Cross and Blue Shield of Florida in Jacksonville, Florida

Report No. 10-41--95-006

June 10, 1997

Our audit of Blue Cross and Blue Shield of Florida (BCBS of Florida), headquartered in Jacksonville, Florida, covered health benefits payments made by the plan between January 1, 1991, and December 31, 1994, along with administrative expenses for the five-year period 1989-1993. In 1994, BCBS of Florida administered benefits for about 127,350 FEHBP subscribers in the state of Florida, representing about 6.9 percent of the total enrollees in the Service Benefit Plan. In that same year, the plan paid about 3.25 million claims for approximately $337 million. For the entire period of 1991-1994, BCBS of Florida paid 12,257,684 claims, totaling $1.3 billion.

As a result of our audit, we questioned $103,473 in health benefits charges, $1,775,086 in administrative expenses, and $28,026 in premium taxes, the latter associated with interest earned on excess funds that should have been returned to the FEHBP. We also determined that the plan had not complied with federal regulations nor its contract terms regarding the management of FEHBP funds, resulting in additional questioned costs of $2,907,486. Lost investment income on these audit findings amounted to $1,745,392 through 1996. Final calculations by our auditors regarding all inappropriate charges to the FEHBP totaled $6,559,463.

Auditors Cite $6,559,463 in Questioned Costs to the FEHBP

Our findings from a previous audit of this plan, covering contract years 1983 through 1987, make it clear that BCBS of Florida has continued its noncompliance in the areas of duplicate payments and unallowable/unallocable charges. In addition, due to the expiration of the contractual records retention periods covering both health benefits payments (three years) and administrative expenses (five years), we were unable to examine approximately $571.9 million in contract charges.

Listed below by audit category are several of the major findings resulting from our

current audit.

Health Benefits

Our auditors examined health benefits, including supplementary and miscellaneous payments, to determine whether BCBS of Florida had complied with its FEHBP contract regarding coordination of benefits, duplicate payments, uncashed checks, and untimely filing of claims. We used the FEHBP contract, the Service Benefit Plan brochure, and the BCBS Association's FEP administrative manual to determine the allowability of benefit payments. Additionally, we interviewed BCBS of Florida personnel and reviewed the plan's policies, procedures, and allocation methods to audit supplementary payments, refunds, and uncashed checks. We questioned a total of $103,473 in the area of inappropriate health benefits costs to the FEHBP. Three findings in this area are summarized below.

Duplicate payments: The plan was able to validate 69 of the original 235 claims we examined as possible duplicate claims. However, in the absence of medical records or physicians' notes, or other documentation from BCBS of Florida, we determined that the plan improperly charged the FEHBP $90,954 for the remaining 166 claims we reviewed as duplicate claims for contract years 1991 through 1994. To date, the BCBS Association has acknowledged only a small number of these claims as duplicates and is contesting the remainder.

Uncashed checks: The plan did not return uncashed checks within the time frame required by its contract, costing the FEHBP $12,519 in lost investment income. Our auditors noted that BCBS of Florida does not have procedures in place to ensure that uncashed checks are handled in accordance with the FEHBP contract. The plan followed one of two patterns: prior to June 1993, the plan returned uncashed checks to the FEHBP annually; after that date, every six months. According to its contract, the plan should have returned the uncashed checks on a monthly basis.

Coordination of benefits: In overseeing claims payments, a carrier is not supposed to pay benefits under its FEHBP contract until it has determined whether it is the primary or secondary carrier or else had been granted permission to pay by the OPM contracting officer. We determined that the plan did not properly oversee the coordination of its claims with Medicare due to inadequate procedures. As a consequence the plan overcharged the FEHBP $2,230,964. The BCBSAssociation responded by stating that a settlement of a dispute between the United States and many BCBS plans executed on October 15, 1995, released those plans from any additional liability under the Medicare Secondary Payer statute. While we acknowledged in our report that this agreement applied to BCBS of Florida, we still encouraged the plan to improve its procedures in this area. We also recommended in our report that the contracting officer require the plan to do so.

Administrative Expenses

We selectively examined the administrative expenses charged to the FEHBP for contract years 1989 through 1993 to determine the allowability, allocability, and

reasonableness of these charges. We determined that there were several instances of unreasonable or improper expenses charged to the FEHBP, resulting in questioned costs of $1,775,086. Some of these findings are listed below and illustrate the type of inappropriate or improper administrative charges we found during the course of this audit.

Gain on self-insured health plan: BCBS of Florida did not credit income earned on its self-insured employee health plan to the FEHBP as required by federal regulation. Consequently, the FEHBP is due a credit of $951,282 for the underwriting gain.

From 1989 through 1993, the premiums paid into the health plan exceeded the claims experience of the plan's employees. The difference was recorded in an expense reimbursement account. We determined that BCBS of Florida did not reduce the health plan expense account by the balance in the expense reimbursement account before allocating the employee health program costs to the FEHBP.

The BCBSAssociation contests this finding, stating that regulations allow contractors who sell insurance to the general public in substantial quantities to treat a self-insured benefit program as purchased insurance. Our position remains that the Federal Acquisition Regulation is very specific about the government's entitlement to a portion of any income, allowance or other credit in this situation, and we have recommended that the agency contracting officer direct the plan to credit the FEHBP for its portion of the gain as previously stated.

Unallowable/unallocable cost center charges: From 1989-1993, the plan charged the FEHBP for cost centers covering regional computer support, membership and billing, utilization review, marketing, chiropractic, lobbying, and HMO information systems, along with health care research and analysis expenses that did not benefit the FEHBP. These unallowable and unallocable costs charged to the FEHBP amounted to $451,043.

Incorrect cost center allocation: Costs must be allocated to the FEHBP based on relative benefits received. Upon review, our auditors discovered that an incorrect allocation rate caused an overcharge of $341,933 to the FEHBP. The BCBS Association did not contest this finding.

Audit Reveals $1,775,086 in Inappropriate Administrative Expense Charges

Cash Management

Cash management: BCBS of Florida did not maintain excess FEHBP funds in a separate, interest-bearing account or credit interest on these funds promptly to the FEHBP. This is a violation of two different sections of federal regulations dealing with the management of FEHBP funds (48 CFR 1652.232-72 and 48 CFR 1652.215-71, respectively).

Our review showed that the plan, in fact, commingled these funds in one of its control-disbursement accounts. Not only did the plan not keep excess FEHBP funds in a separate income-producing account, it held these funds on average nine days before the checks it issued to satisfy FEHBP-related health benefits claims were presented to

the bank. The BCBS Association would draw from the FEHBP letter of credit (LOC) account and reimburse the plan one day after the claims were processed. The LOC account was created to ensure that local BCBS plans were reimbursed within a reasonable time frame for their FEHBP-associated expenses, including paying health benefits. It was intended to operate on a "checks-presented" basis, meaning that BCBS plans would receive their reimbursements at the time their checks were actually presented to the bank. At the time of this audit, this account was managed by the BCBS Association. Now, it is managed by OPM and does operate under the "checks-presented" system.

Improper Cash Management by Plan Costs FEHBP $2,907,486

Employee Organization Plans

These plans also fall in the category of experience-rated and may operate or sponsor participating health benefits programs. Employee organization plans operate on an indemnity and fee-for-service basis. Members are free to obtain treatment through facilities or providers of their choice for which claims are submitted to the carrier for adjudication and payment.

During the reporting period, we issued two employee organization plan audit reports. One of these is summarized in the following narrative.

Mutual of Omaha Insurance Company as Underwriter for the Foreign Service Benefit Plan in Charlotte, North Carolina

Report No. 40-10--95-008

September 22, 1997

Mutual of Omaha Insurance Company (Mutual), located in Omaha, Nebraska, served as underwriter for the Foreign Service Benefit Plan (FSBP) during the contract period we audited (1992-1994). FSBP is an experienced-rated employee organization plan offering indemnity benefits to its subscribers. This means that the cost experience of providing benefits in prior years, including underwriting gains and losses, are reflected in current and future years' premium rates.

FSBP conducted the general administration of plan activities, such as enrollment functions, while subcontracting its underwriting activities, including claims processing, to Mutual of Omaha. We conducted this audit in Charlotte, North Carolina, where Mutual's claim processing operations, including first-level claims review and customer services activities, are located. Findings relating to two previous audits of Mutual as FSBP underwriter have been resolved. With respect to these audits, the first covered Mutual's claim processing operations during contract years 1982-1985; the other examined administrative expenses and premium taxes

from 1986 through 1991.

Our current audit was limited to health benefits charges. It was designed primarily to determine whether these claims were processed and paid in accordance with the benefits described in FSBP's benefits brochure and met OPM contract requirements.

After completing this audit, we questioned $117,846 in costs related to health benefit payments made by Mutual. These payments included $111,673 in claims not properly coordinated with Medicare and $6,173 in duplicate payments. An additional $25,837 is due the FEHBP for lost investment income associated with the questioned costs cited.

More detailed information on some of our specific findings and recommendations can be found below.

Auditors Determine $117,846 in Inappropriate Health Benefits Charges

Health Benefits

Coordination of benefits: For contract years 1992 through 1994, Mutual did not coordinate all claims with Medicare as required by its contract. The result was a $111,673 overcharge to the FEHBP. In its response, Mutual agreed that $32,218 of this amount was accurate. Mutual further stated that it had received $26,723 in refunds, leaving $52,732 unrecoverable because of the age of the claims. We reviewed Mutual's documentation regarding the refunds and agreed with $12,904 of the $32,218 they had claimed in refunds. We suggested to Mutual that it make a diligent effort to recover the remaining claim overpayments, including offsetting these overpayments with future claim payments. We have also recommended that the contracting officer require Mutual to return $26,723 to the FEHBP in documented refunds received by the plan and to continue to pursue recovery of the remaining $84,950 in uncoordinated claims.

Internal Controls

Data integrity: We determined that Mutual did not reconcile claims-related data it maintained in its various computer systems, including the claims processing, draft clearing, and paid-accounting systems. Because these systems were not reconciled to each other by Mutual, the accuracy and completeness of the data were unreliable. As a result, during our audit, we were unable to fully reconcile the detailed claim history to the annual accounting statement filed with OPM. As a consequence, we recommended that the OPM contracting officer require Mutual to reconcile all databases used to generate claims payments to each other and to the annual accounting statement. Mutual did not specifically comment on this recommendation.

Data inconsistency: We observed several instances where claims data was not consistently coded or the relationship between data fields was contradictory. As a result of these types of inconsistencies, the system controls did not identify potential problems with claim payments. This problem, for instance, contributed to the FEHBP overcharges that occurred regarding the coordination of benefits with Medicare cited previously.

Other inconsistencies we discovered also dealt with Medicare-related data. We matched Medicare enrollment information to individual claim records and found several problems. For example, we noted multiple Medicare enrollment dates for enrollees, enrollees with no termination dates, and Medicare enrollment records without an effective date.

As a result, we have recommended to the OPM contracting officer that Mutual be required to implement better internal controls to achieve a complete, accurate, and consistent database of individual claim records and enrollment information.

Auditors Cite Need for Improved Internal Controls

OTHER EXTERNAL AUDITS

As requested by Office of Personnel Management procurement officials, our OIG conducts pre- and post-award contract audits relating to the acquisition of goods and services by agency program offices. Our office also conducts audits of the local organizations of the Combined Federal Campaign (CFC), the solely authorized fund-raising drive conducted in federal installations throughout the world .

Pre-Award and Post-Award Contracts

These contract audits are performed to ensure that costs anticipated to be, or claimed to have been, incurred under the terms of these contracts are accurate and in accordance with provisions of the Federal Acquisition Regulation. The results of these audits provide OPM procurement officials with the best information available for use in contract negotiations and oversight. In the case of post-award contracts, for instance, the verification of actual costs and performance charges may be useful in negotiating contract modifications as these relate to cost-savings and efficiency.

We did not conduct any external contract audits in this area during the reporting period.

Combined Federal Campaign

On March 18, 1961, Executive Order 10927 transferred to the chairman of the U.S. Civil Service Commission (the precursor of OPM) the responsibility to arrange for national voluntary health and welfare agencies to solicit funds from federal employees and members of the armed services at their place of employment. Since then, there have been two more executive orders, one public law (P.L. 100-202), and the issuance of federal regulations (5 CFR 950) detailing the eligibility of national and local organizations and charities as CFC participants, the role of local CFCs, and the oversight responsibilities of the Office of Personnel Management relating to the Combined Federal Campaign.
Our oversight responsibilities include auditing the local CFCs and reviewing audits performed by independent certified public accountants (CPAs). Our audits focus on the eligibility of local charities participating in the campaigns, local campaign compliance with CFC regulations, and the testing of the various local campaigns' financial records. CFC audits will not ordinarily identify savings to the government, because the funds involved are charitable donations made by federal employees.

Our agency requires annual audits be performed by independent CPAs for large campaigns with total gross receipts of over $250,000. These CPAs are required to offer an opinion on both compliance with regulations and the financial activities of these campaigns. To assist local CFCs with these audits, OPM provides them written audit guidance.

For local campaigns with total gross receipts of $250,000 or less, OPM does not require an audit, but the campaigns must complete a compliance assessment provided by OPM. For organizational purposes, each local campaign must have an organization, usually a local charity, called the Principal Combined Fund Organization (PCFO). This entity is responsible for training employee keyworkers and volunteers; preparing pledge cards and brochures; distributing campaign receipts; responding in a timely and appropriate manner to all inquiries from participating organizations, OPM's Director, etc.; and consulting with federated groups on the operations of the local campaign. While audits of these campaigns are not required, each PCFO's overall organization must still be audited annually and maintain all organization and campaign financial records in accordance with generally accepted accounting principles.

Since 1961, the CFC has netted over $3.4 billion in charitable contributions. Approximately 391 local campaigns participated in the 1996 CFC, the most recent year for which statistical data was available. Federal employee contributions reached $193.6 million for the 1996 CFC, while expenses totaled $15 million.

During the current reporting period, the CFC program office within OPM referred to the OIG for our review 16 reports it had received from large campaigns and 16 compliance assessments received from small campaigns. Upon completion of our reviews, we reported to the CFC program office that, of the 32 campaigns, 12 did not meet OPM's reporting requirements. In addition, we made several suggestions pertaining to OPM's CFC reporting requirements and guidance in areas we felt needed clarification and expansion. With respect to our own CFC audits during this reporting period, we performed several for which final reports have not yet been issued.

Auditors Note Several CFCs Did Not Meet Reporting Requirements

OPM INTERNAL ACTIVITIES AUDITS

Our office also has responsibility for conducting a wide range of audit activity covering OPM programs and administrative operations. This activity includes such diverse areas as financial statement audits required by the Chief Financial Officers Act (CFO Act); President's Council on Integrity and Efficiency government-wide audits; audits of agency compliance with laws and regulations, such as the Prompt Payment Act and the Federal Managers' Financial Integrity Act; and performance audits of OPM programs that involve the range of the agency's responsibilities for retirement, employee development, and personnel management activities.

We have established a one-to-five-year optimum audit cycle for each of the aforementioned audit areas, depending upon the existence of legal requirements to conduct audits and the materiality and other risk factors associated with each activity.

Due to resource limitations, we have eliminated all internal agency audits from our agenda with the exception of OPM's financial statements audits. As a consequence, our office did not issue any audit reports concerning OPM programs and administrative activities during this reporting period. However, our Office of Evaluation and Inspections continues to perform evaluations of agency program and administrative activities. For a summary of those activities, please refer to the Evaluation and Inspections Activities section of this report on pages 35-38**.**

Agency Financial Statements Audits

As mentioned in our semiannual report released in the fall of 1996, we elected to have the OPM fiscal year 1996 benefits programs financial statements audited by an independent public accounting firm, with OIG auditors overseeing the audit. As also stated, OPM program management agreed to provide funding for this contract, which was awarded in November 1996. These audits, commencing immediately thereafter, covered financial statements related to OPM's health, life insurance, and retirement benefits programs.

Our office monitored the benefits programs financial statements audits to ensure that the IPA performed all work in accordance with the contract and compliance with government auditing standards and other authoritative references pertaining to OPM's financial statements. Our review of the work papers and reports provided sufficient evidence for us to concur with the IPA's opinions. A summary of the report we issued on the IPA's audit appears in this section.

Additionally, OIG auditors attempted to perform our office's first full-scope audit of OPM's revolving fund (RF) and salaries and expense accounts (S&E) financial statements. However, during the course of this audit, we concluded that we would be unable to give an opinion on the fairness of the statements due to limitations on our scope of work resulting from incomplete agency record keeping, among other problems. We have provided an audit narrative on this report, summarizing this and other aspects of our

findings.

We also released an audit report during the reporting period pertaining to internal controls and related management issues associated with OPM's FY 1995 and 1994 financial statements. A summary of that report is also described in this section.

Office of Personnel Management's Fiscal Year 1996 Benefits Programs Financial Statements

Report No. 2F-00-96-104

June 17, 1997

Under provisions of the CFO Act, our office is required to audit and report on the financial statements of OPM's reporting entities or select an independent accounting firm to do so. Under a contract monitored by our office, the international accounting firm of KPMG Peat Marwick LLP (KPMG) performed audits of OPM's fiscal year 1996 benefits programs financial statements.

As mentioned on the preceding page of this report, the benefits programs financial statements reviewed during this audit covered the health, life insurance, and retirement programs, programs that are key to the uninterrupted flow of benefits to federal civilian employees, annuitants, and their respective dependents. These primary benefits programs operate under the following names: the Federal Employees Health Benefits Program, the Federal Employees' Group Life Insurance Program, the Civil Service Retirement System (CSRS), and the Federal Employees' Retirement System, all administered by OPM's Retirement and Insurance Service.

KPMG's fiscal year 1996 audit report includes opinions on the benefits program financial statements as well as reports on internal controls and the agency's compliance with laws and regulations pertaining to these programs. A summary of its audit work is reflected below.

Retirement Benefits Program

Retirement program. KPMG issued a qualified opinion on the retirement program (RP) financial statements due to inadequate controls over the determination and payment of benefits to annuitants. In its accompanying report on internal controls, KPMG identified material weaknesses in the following areas:

- Accounting and internal control systems need improvement.
- Financial management should be enhanced to provide for clearer integration of operational objectives with management and employee responsibilities.
- Management should establish controls to determine whether the benefit

payments made to annuitants are accurate.

In addition, the IPA found that OPM did not comply with certain laws and regulations. Findings included noncompliance with Office of Management and Budget (OMB) Circular A-127, Financial Management Systems; OMB Circular A-123, Management Accountability and Control; and the Federal Managers' Financial Integrity Act. They also determined that investments received in a security exchange with the U.S. Treasury were not authorized security investments.

Health Benefits Program

Health benefits program. KPMG issued a disclaimer of opinion on the health benefits program (HBP) FY 1996 financial statements, commenting that adequate evidential matter was not available to support transactions and balances related to insurance premiums and activity of all carriers.

The HBP has made significant improvements in its control environment over the past four years. However, KPMG continued to find material internal control weaknesses in the following areas:

- Accounting and internal control systems need improvement.
- Financial management should be enhanced to provide for clearer integration of operational objectives with management and employee responsibilities.
- OPM has not established an adequate control system over insurance premiums and experienced-rated carrier (ERC) activity and balances recorded in the HBP financial statements.

In addition, KPMG found that OPM also did not comply with certain laws and regulations in the HBP area. Findings included noncompliance with OMB Circular A-127, OMB Circular A-123, and the FMFIA.

Life Insurance Benefits Program

Life insurance program. KPMG issued an unqualified opinion on the life insurance program (LP) financial statements. Its report on internal controls identified material weaknesses in the following areas:

- Accounting and internal control systems need improvement.
- Financial management should be enhanced to provide for clearer integration of operational objectives with management and employee responsibilities.

Once again, KPMG found that OPM did not comply with certain laws and regulations. Findings included noncompliance with OMB Circular A-127, OMB Circular A-123, and the FMFIA.

OIG Monitors IPA Audits of FY 1996 Benefits Program

Report on Office of Personnel Management's Fiscal Year 1996 Revolving Fund and Salaries and Expense Accounts Financial Statements

Report No. 2F-00-96-102

July 2, 1997

Our work this period included the first attempt at full-scope audits of the revolving fund and salaries and expense accounts financial statements. Due to significant limitations on the scope of our work, we were unable to express an opinion on the FY 1996 financial statements. These scope limitations were due mainly to the inability of the Office of the Chief Financial Officer (OCFO) to provide standard accounting records for substantially all of the material accounts and line items represented in the statements.

Revolving Fund Financial Statements

Revolving fund. We also identified several material internal control weaknesses during our audit of the RF financial statements. These included the following:

- Operating policies and procedures were either not current or not documented for substantially all accounts and line items.

- Reconciliations and supervisory reviews of transactions with the US Investigations Service, Inc. (a private-sector contractor), were not performed or were incomplete.

- Poor cash reconciliation procedures have resulted in unreconciled differences of approximately $22 million between the RF cash general ledger balances and U.S. Treasury records, such as the TFS 6653 - Undisbursed Appropriation Account Ledger.

- Year-end adjustments to account balances totaling $40 million for the purpose of preparing the financial statements were not recorded in the general ledger.

- Accounts receivable aging schedules were not prepared on a regular basis, and past due notices were not sent to debtors during FY 1996.

In addition, we reported that the FMFIA report filed by OPM did not include all RF material weaknesses. These weaknesses included transactions with the US Investigations Service, Inc., and unrecorded year-end adjusting entries.

Salaries and Expenses Accounts Financial Statements

Salaries and expenses accounts. We also identified several material internal control weaknesses during our audit of the S&E financial statements. These included the following:

- Operating policies and procedures were either not current or not documented for substantially all accounts and line items.
- Poor cash reconciliation procedures resulted in unreconciled differences of approximately $2.2 million between the S&E cash general ledger balances and U.S. Treasury records, such as the TFS 6653 - Undisbursed Appropriation Account Ledger.
- Year-end adjustments to account balances totaling $75 million for the purpose of preparing the financial statements were not recorded in the general ledger.
- Accounts receivable aging schedules were not prepared on a regular basis, and past due notices were not sent to debtors during FY 1996.
- Property and equipment acquisitions transactions were not recorded in a timely manner; reconciliations of the subledger to the general ledger were not performed; transactions were not adequately reviewed by supervisors; and the subledger was not integrated with the general ledger.

We also reported that the FMFIA report filed by OPM did not include all S&E material weaknesses. These weaknesses included unrecorded year-end adjusting entries and controls over property and equipment transactions. The FMFIA report also did not include the nonconformance with OMB Circular A-127 caused by the failure to integrate the property and equipment subledger with the general ledger.

OIG Issues Disclaimer of Opinion on FY 1996 RF & S&E Financial Statements

Report on Internal Control and Related Management Issues From the Audits and Related Work on the Office of Personnel Management's Fiscal Year 1995 and 1994 Financial Statements

Report No. 2F-00-96-101

May 21, 1997

This report was based upon the audit work that our office performed during the FY 1994 and 1995 audits of OPM's financial statements. Our reports and opinions on OPM's fiscal years 1994 and 1995 benefits programs financial statements were issued on March 3, 1995, and May 29, 1996, respectively. These reports also included results of our compilation and agreed-upon procedures for the RF and S&E Accounts.

Opportunities for Improvement in

During the course of that audit work, we identified opportunities for improvement in OPM's financial operations. Among the key opportunities we noted were the following:

- ***Policy changes for the FEHBP administrative expense reserves.*** If adopted, the policy changes recommended may increase annual cash flow to the FEHBP by up to $130 million. Annually, over $120 million that could be used for critical program needs is provided to carriers. We recommended that OPM seek authority to utilize reserve funds for immediate and long-term administration needs of the program.

- ***Enhancement of the RP debt collection procedures.*** We recommended that OPM's Retirement and Insurance Service develop a debt collection strategy incorporating the Debt Collection Improvement Act, passed in April of 1996, to address the $96 million due the RP for overpaid benefits, including $58 million of delinquent debt. New procedures to minimize the occurrence of and improve collections of overpayments, including regular billings and follow-up contact with debtors, should be implemented. We acknowledge that OPM initiated several of these procedures in FY 1996 and is proceeding on the path to improved debt collections.

Benefits Programs Internal Controls and Compliance with Laws and Regulations

As a result of our audit work, we identified areas that represent material weaknesses in the internal control structure. For each weakness, we have provided OPM management with specific recommendations for improvement. Each of the areas contains elements that are reportable as material weaknesses under the requirements of the FMFIA.

The tables that appear on page 26 include reportable conditions that we identified during our audit work in addition to those reportable conditions that we consider to be material weaknesses in the internal controls. Material weaknesses that were not reported in OPM's FY 1995 or 1994 FMFIA reports are noted with an asterisk. The tables are followed by brief descriptions of the material weaknesses.

As indicated in Table 1, OPM corrected three material weaknesses in FY 1995, leaving four remaining uncorrected material weaknesses. These remaining material weaknesses include the following:

- ***Operating policies and procedures not documented and systems not integrated.*** This is a critical weakness that was first identified in 1991. This is an overriding problem that if corrected would assist in correcting many of the other

weaknesses that we have reported. The majority of the areas we audited were accounted for by electronic systems that were not documented by current and complete user manuals, operations manuals, and program maintenance manuals. Lack of current, tailored policies and procedures increases the risk to the agency of improper recording of financial information and ultimately increases the risk of fraud, waste and abuse. In addition, none of the HBP, RP, and LP subsystems we audited were integrated with the general ledger system required by OMB Circular A-127, Financial Management Systems. Lack of systems and procedures documentation and non-integrated systems are central contributors to substantially all the internal control issues identified during our audits of OPM's FY 1991 through FY 1995 financial statements.

- ***Retirement program public receivables not effectively managed and collected***. Beginning in fiscal year 1991, our audits of the RP public receivables disclosed weaknesses in internal controls for debt management and debt collection. In addition to a lack of documented policies and procedures and integrated systems, we also determined that basic internal control elements were often ineffective or missing.
  In many cases, reconciliations of general ledger control accounts with detailed information from the subsystems were not performed. Management reports on the age and status of accounts were not available from all systems. Further, compositions of the general ledger balances for some types of receivables, such as recertification receivables, did not exist. Without the availability of basic information such as the name and address of the debtor, date of debt, and individual account amounts, management could not effectively collect these debts.

- ***Inadequate control over annuitant withholdings***. The RP withholds various amounts from monthly annuitant and survivor payments. These withholdings include amounts for health benefit premiums, life insurance premiums, federal income taxes, state income taxes, and other annuitant obligations. The program is responsible for paying health and life insurance premiums to the HBP and LP administered by OPM. In addition, the RP is responsible for remitting withholdings to the Internal Revenue Service, numerous states, and various other third parties. Our previous audit of the FY 1993 benefit programs financial statements identified material internal control weaknesses in the annuitant withholding area. Although RIS has made some improvements, these weaknesses continued to exist through FY 1995.

- ***Inadequate health benefits financial reporting and agency oversight of insurance carrier activities***. Beginning with our audit of the FY 1991 financial statements, we identified material internal control weaknesses in the financial reporting, data accumulation, estimation and consolidation process used by HBP to account for ERC transactions and balances. In addition, we identified weaknesses with financial management controls over ERCs and

with program oversight of ERC activity. These continue to exist and are preventing the audit of this activity.

Table 1.

Fiscal Year 1995 t Internal Controls Weaknesses			
Issues	**Retirement Program**	**Health Insurance Program**	**Life Insurance Program**
Operating Policies and Procedures and Systems Integration	M	M	M
Electronic Data Processing - General Controls	RC	RC	RC
Agency Reports of Enrollment and Collections	RC	RC	RC
Public Receivables	M	N/A	RC
Annuity Payments - Amounts Withheld and Payable (Transactions and Balances)	M*	M*	M*
Reconciliation of Non-check Contributions and Unidentified Cash with Treasury	RC	RC	RC
LP Financial Reporting (Loss Contingency)	N/A	N/A	RC
Experience-rated Carriers - Oversight and Financial Reporting	N/A	M*	N/A

Table 2.

Fiscal Year 1994 Internal Controls Weaknesses			
Issues	**Retirement Program**	**Health Insurance Program**	**Life Insurance Program**
Operating Policies and Procedures and Systems Integration	M	M	M
Electronic Data Processing - General Controls	M*	M*	M*
Agency Reports of Enrollment and Collections	M	M	M
Public Receivables	M	RC	RC
Annuity Payments - Amounts Withheld and Payable (Transactions and Balances)	M*	M*	M*
Reconciliation of Non-Check Contributions and Unidentified Cash with Treasury	M*	M*	M*
Agency Contributions	RC	RC	RC
Experience-Rated Carriers - Oversight and Financial Reporting	N/A	M	N/A

M = A reportable internal control weakness considered to be a material weakness.
M* = A material weakness in internal control that was not included or properly reported in OPM's FMFIA report for the year in question.
RC = A reportable condition
N/A = Not applicable

Revolving Fund and Salaries & Expenses Accounts
Internal Control Weaknesses

Our work on the FY 1995 and 1994 financial statements was limited to compilations and certain agreed-upon procedures. As a result of this work, we identified several internal control weaknesses that we deemed to be reportable conditions. These included the following:

y

- ***Unreconciled differences between U.S. Treasury records and S&E and RF cash records***. As of September 30, 1995, cash balances for both the S&E and RF accounts were materially different from balances per the U.S. Treasury. Adjustments were made by the OCFO to bring the balances into agreement with Treasury's balance. However, no documentation supporting the adjustments was provided. The adjustments were credits to cash for approximately $31.2 million and $27.6 million for the S&E and RF, respectively .

- ***S&E and RF accounts receivable balances not supported by underlying records.***

- ***Material year-end adjusting entries not recorded in the general ledger.***

- ***Lack of written policies and procedures for the preparation of S&E and RF financial statements.***

OIG Auditors Identify Financial Reporting Weaknesses

Health Insurance Carrier Financial Accountability

Our office and RIS have maintained a high level of effort working to bring better financial accountability and increased oversight to the FEHBP. These efforts are evidenced by the Experience-Rated Health Insurance Carrier Quality Improvement Team (ERCQIT), originally formed during the fall of 1995 to ensure that the insurance carriers met federal government financial reporting and audit requirements. The lack of adequate oversight and control over ERC-reported amounts and balances used for financial statement reporting is a material weakness that contributed to a disclaimer of opinion on the FEHBP's fiscal year 1996 financial statements. In addition to OPM and OIG representatives, the QIT included health insurance carriers and their independent public accountants. During September of 1996, the ERCQIT developed several recommendations to improve controls and accountability.

The most critical recommendation called for the development of an audit guide for carriers that would provide for improved controls over carrier-processed activity.

The audit guide describes expanded audit procedures to be conducted by the IPAs of the health insurance carriers' FEHBP operations. When implemented, we believe these procedures will lead to the elimination of the disclaimer of opinion on the FEHBP financial statements. As such, the QIT has focused its efforts on drafting an audit guide. The first draft of the audit guide was submitted for comment to the carriers and their IPAs in June of 1997. The ERCQIT has resolved a majority of these comments and expects to issue the final audit guide this fall.

As part of their QIT participation, several carriers have agreed to participate in a pilot program during the current fiscal year. The pilot program will provide an opportunity to test the audit guide before it is required for all carriers in FY 1998.

The ERC audit guide provides the OIG with new opportunities to expand the scope of our work in the highly vulnerable health insurance area. As mentioned in the Message From the IG section of this report, the infrequency of audits of FEHBP insurance carriers has been reported as an agency material weakness under FMFIA. The IPA work related to assessing internal controls will help eliminate this weakness and target carrier program operations where the internal controls are weak. By combining the work of the IPA with our own work, we will be able to expand the level of oversight of FEHBP carrier operations significantly.

Agency Efforts to Improve Carrier Financial Accountability Continue

OIG Assists OCFO Efforts to Improve Internal Controls

As noted in the audit narrative regarding OPM's revolving fund and salaries and expense accounts, our audit of these two administrative entities has resulted in disclaimers of opinion on both the RF and S&E financial statements. In an effort to effect program-wide controls, the OCFO requested assistance from our office in correcting the identified material weaknesses. Accordingly, we have detailed one of the OIG's senior managers from the Office of Audits to OCFO to assist in OCFO's efforts to improve the internal control structure and increase the reliance users could put on data produced within that control structure.

In addition, the OIG will be participating in various QITs with the OCFO. These QITs will cover a variety of critical areas and provide the OCFO and OIG an opportunity to improve controls in an efficient and effective manner.

Investigative Activities

The Office of Personnel Management administers benefits from its trust funds for all federal civilian employees and annuitants participating in the federal government's retirement, health and life insurance programs. These trust fund programs cover approximately 9.1 million current and retired federal civilian employees and their family members and disburse over $57 billion annually. The investigation of fraud involving OPM's trust funds occupies the majority of our OIG investigative efforts.

During this reporting period, we have continued to aggressively pursue criminal and civil sanctions against both individuals and corporate entities. These efforts have produced 12 arrests and 11 convictions. More importantly, however, they have resulted in judicial and administrative monetary recoveries totaling $4,647,512. Other investigative efforts resulted in the detection of five ongoing frauds in the Civil Service Retirement System, with a projected savings of $173,526 to the Civil Service Retirement and Disability trust fund over the next five years. Overall, we opened 16 investigations and closed 27 during this reporting period, with 107 still in progress at the end of the period. (See Table 1 for investigative activity highlights on page 34 this section.)

Calls received on our retirement and special investigations hotline and our health care fraud hotline, along with complaints mailed in, totaled 1,017. As we typically experience during the second half of the fiscal year, our complaint activity has decreased from the previous reporting period. Complaint activity is usually more active in the fall of each year when the FEHBP open season brochures, which contain information on how to report fraud to the OIG, are distributed. Additional information, including specific activity breakdowns for each hotline, can be found on page 33 in this section.

With respect to the FEHBP trust fund, we have been very successful in monetary recoveries during the reporting period. The result of those efforts is evidenced in out-of-court settlements with two FEHBP providers that yielded substantial returns to the FEHBP trust fund. Details of those cases can be reviewed in narratives appearing on pages 31-32, respectively.

In the retirement area, we have continued our proactive efforts to identify fraud by routinely reviewing CSRS annuity records for indications of unusual circumstances, as well as maintaining contact with the federal annuitant population. While our recoveries in this area are, for the most part, smaller than in the health care fraud area, criminal prosecutions and sentences tend to be more significant. In addition to the typical fraud scenarios involving individuals who continue to take the annuity payments issued to deceased beneficiaries, cases involving more unique methods of retirement fraud were investigated and closed during this period. Two of these cases are highlighted on pages 30-31.

On the following pages, we have provided narratives relating to health care and retirement fund fraud and abuse cases we worked and closed during the reporting period.

Retirement Fraud and Special Investigations

In accordance with our mission to prevent and detect fraud, OIG special agents routinely review CSRS annuity records for indications of unusual circumstances. Using excessive annuitant age as an indication of potential fraud, our investigators attempt to contact the annuitants and determine if they are alive and still receiving their benefits. In addition, we receive inquiries from OPM program offices, other federal agencies and private citizens that prompt us to investigate cases of potential retirement fraud or alleged misconduct by OPM employees and contractors.

Cited below are narratives related to two of the cases in these areas that we completed during this reporting period.

Family Member Identified in Annuity Fraud

In December 1994, the Federal Bureau of Investigation's office in Omaha, Nebraska, contacted our office, alerting us to the fact that annuity payments had been issued to a deceased CSRS annuitant. Our office initiated an investigation concerning these annuity payments and determined that the annuitant had died in May 1988 and that these annuity payments continued until May 1994 when the FBI informed OPM's Retirement and Insurance Service in Boyers, Pennsylvania, that the annuitant was dead. For this six-year period, the overpayment amounted to $165,958.

During the course of our investigation to determine who might have received this money, the annuitant's son, a former certified public accountant with prior forgery convictions, became a suspect. Though the son initially denied involvement in the case, he eventually admitted forging his father's name on checks and on four OPM verification documents. He subsequently pleaded guilty to theft of government funds and was sentenced to 18 months in jail and 3 years of probation. He also was ordered to perform 300 hours of community service and to make restitution to the Civil Service Retirement and Disability trust fund in the amount of $79,175.

Joint Investigative Efforts Result in Guilty Plea

Rehired Federal Employee Caught In CSRS Annuity Fraud

Our office initiated an investigation in this case after receiving information from OPM's Retirement and Insurance Service that a current federal employee was also receiving a full CSRS retirement annuity.

In November 1993, this individual retired from her job with the Alaskan Railroad, a former federal entity operated until 1985 by the Department of Transportation's Federal Railroad Administration, at which time it came under the control of the state of Alaska. As a "grandfathered" federal employee, she was entitled to and immediately began receiving her annuity payments. However, in May 1994, she applied for and was hired as a full-time employee by the U.S. Department of Energy's Alaska Power Administration.

Our investigation revealed that, on two separate application forms, she indicated that she was not receiving a federal civilian retirement pension. We interviewed the employee in Palmer, Alaska, at which time she admitted lying on her application regarding her federal annuity. OPM determined that the total overpayment, including health benefits, was $100,483.

The employee subsequently pleaded guilty to violating one count of 18 U.S.C. § 641, theft of public money. As part of her sentence, she was directed to participate in the Department of Justice (DOJ) curfew/home confinement program, which required her to be electronically monitored for up to 180 days and pay a monitoring fee of $4.97 per day. She also was placed on one year's probation, ordered to make restitution in the amount of $100,483, as well as pay both a $2,000 fine and a $50 special assessment.

CSRS Annuitant Ordered to Make Restitution in the Amount of$100,483

Health Care-Related Fraud and Abuse

Our OIG special agents are in regular contact with the numerous insurance carriers participating in the FEHBP to provide an effective means for reporting instances of possible fraud by health care providers and FEHBP subscribers. Our office also maintains liaison with federal law enforcement agencies involved in health care fraud investigations and participates in several health care fraud working groups on both national and local levels. Additionally, we work closely with our own Office of Audits when fraud issues arise during the course of health carrier audits.

The following narratives describe two of the cases we concluded in the area of health care fraud during this reporting period.

Provider Overcharges Result in Monetary Settlement

In February 1997, at the request of the Department of Justice in Washington, D.C., our office initiated an investigation of EmCare Group Inc. (EmCare), a contract management company that, through its affiliates, staffs numerous emergency

departments in hospitals throughout the country. EmCare used Emergency Physicians Billing Service (EPBS) to perform its emergency room billings.

At the same time that we began our investigation, EPBS was also involved in a civil case for allegedly incorrectly billing insurance companies. As a result, EmCare approached the DOJ and agreed to cooperate with the government concerning billings submitted by EPBS on behalf of EmCare.

After obtaining payment information on EPBS from an FEHBP carrier for the period 1991 through 1996, our OIG computer programming staff analyzed this data and was able to project the FEHBP's entire billing exposure to EPBS and use these projections to determine a damage figure. As a result of these figures and others provided to the Department of Justice by the OIGs at the Department of Health and Human Services (HHS) and the Department of Defense, EmCare agreed to a civil settlement with the federal government in the amount of $7,750,000. Of that amount, $777,997 was returned to the FEHBP trust fund.

FEHBP Trust Fund Receives $777,997 from Civil Settlement

Clinical Laboratory Billing Fraud Uncovered

As referenced in our last semiannual report, beginning in 1993, the U.S. Attorney's office requested our agency to enter into a national health care fraud initiative targeting clinical laboratories in the United States. Some of these national laboratories were found to have engaged in billing schemes that resulted in insurance carriers paying these labs directly for tests not specifically ordered by individual physicians or collecting on charges for individually billed tests that physicians had understood were included in a single billing package. The net effect was not only the insurance carriers being misled, but the physicians as well.

One such investigation conducted by the U.S. Attorney's Office for the District of Columbia, HHS, and the FBI revealed that Laboratory Corporation of America (Labcorp), through its subsidiary labs (National Health Labs, Allied Laboratories, and Roche Biomedical Laboratories), submitted numerous fraudulent health insurance claims, including claims to FEHBP health carriers.

Through further investigation, our office was able to determine that, between 1988 and 1996, fee-for-service health carriers participating in the FEHBP paid approximately $6,843,468 as a result of Labcorp's questionable billing practices. Those figures were
provided to the Department of Justice, resulting in a civil settlement agreement with Labcorp. Specifically, Labcorp agreed to pay the federal government $182 million. Of that amount, $2,989,089 was returned to the FEHBP trust fund.

OPM Awarded Approximately $2.99 Million in Provider Settlement

OIG Hotlines

The OIG maintains two hotlines, the Retirement and Special Investigations hotline and the Health Care Fraud hotline.

Retirement and Special Investigations Hotline

The Retirement and Special Investigations hotline provides the same assistance as traditional OIG hotlines. For example, we receive inquiries from OPM employees, contractors, and others interested in reporting waste, fraud and abuse within the agency. Callers, or those who choose to write letters, can report information openly, anonymously or confidentially without fear of reprisal.

The Retirement and Special Investigations hotline and complaint activity for this reporting period included 61 telephone calls, 62 letters, 23 agency referrals, and 131 complaints initiated by the OIG, for a total of 277. Our administrative monetary recoveries resulting from retirement and special investigation complaints totaled $166,695.

OIG-initiated complaints: Complaints initiated by our office can be one of two types. The first occurs when the agency has already received information indicating an overpayment to an annuitant has been made, and our review leads us to determine there are sufficient grounds to justify our involvement due to the potential for fraud. There were 16 such complaints associated with agency inquiries during this reporting period.

The second type of OIG-initiated complaint occurs when we review the agency's automated annuity records system for certain items that may indicate a potential for fraud. At that point, we initiate personal contact with the annuitant to determine if further investigation is warranted. This proactive activity resulted in 115 instances where our office initiated personal contacts to verify the status of the annuitant.

Health Care Fraud Hotline

The Health Care Fraud hotline was established to handle complaints from subscribers in the Federal Employees Health Benefits Program administered by OPM. The hotline number is listed in the brochures for all the plans associated with the FEHBP.

While the hotline is designed to provide an avenue to report fraud by subscribers, health care providers or FEHBP carriers, frequently callers have requested assistance

with disputed claims and services disallowed by the carriers. Each caller receives a follow-up call or letter from either the OIG hotline coordinator, the insurance carrier or another OPM office as appropriate.

The Health Care Fraud hotline and complaint activity for the period involved 567 telephone calls and 173 letters, for a total of 740. During this period, the administrative monetary recoveries pertaining to health care fraud complaints totaled $30,657.

Investigative Activity Tables

TABLE 1: Investigative Highlights

Judicial Actions:

Arrests	12
Indictments	11
Convictions	11

Administrative Actions:[1]	2

Judicial Recoveries:

Fines, Penalties, Restitutions and Settlements	$ 4,450,160

Administrative Recoveries:

Settlements and Restitutions	$ 197,352

Total Funds Recovered	**$4,647,512**

[1] *Includes suspensions, reprimands, demotions, resignations, removals, and reassignments.*

TABLE 2: Hotline Calls and Complaint Activity

Retirement and Special Investigations Hotline and Complaint Activity:

Retained for Investigation	203
Referred to:	
OIG Office of Audits	0
OPM Groups and Offices	34
Other Federal Agencies	40
Total	**277**

Health Care Fraud Hotline and Complaint Activity:

Retained for Investigation	169
Referred to:	
OPM Groups and Offices	186
Other Federal/State Agencies	112
Health Insurance Carriers or Providers	273
Total	**740**

Total Contacts	**1017**

Evaluation and Inspections Activities

Section 4(a)(3) of the IG Act directs IGs to conduct activities to promote economy and efficiency. We have defined evaluation and inspections as a core function of our office. Through this function, we are providing assistance to agency program managers in their efforts to determine the feasibility of new initiatives and the effectiveness and efficiency of existing operational methodologies. We conduct independent analytical reviews that often serve as the cornerstone for strategies to improve the delivery of services throughout the agency.

Our office provides this agency with a unique tool to address some of the pressing issues associated with today's government reorganizing. The evaluative process we employ, whether requested or mandated, focuses on current issues, such as reduced funding, increased workloads, decreasing staffing levels, inefficient or ineffective services, private or public sector inquiries concerning delivery of services, and the absence of objective evaluative data to use in determining the impact of programs.

OPM has been in the forefront of the Administration's efforts to improve the quality of its services and reduce the size of government. Its program offices have experienced reorganizations, staff reductions, and new program mandates during the last few years, with the intended goal of becoming a "model agency" for the twenty-first century. Questions have been raised both within the agency and from other interested parties concerning how OPM will be able to meet these challenges. We are now working with agency offices to conduct evaluations of existing services that will help them formulate strategies to improve services, increase accountability, and minimize resource demands.

At the outset of the reporting period, this function was operating at one half of its normal staffing level, leaving only two evaluators to conduct agency program reviews. Not only was the loss of staff a major impediment in sustaining the desired degree of productivity, but it substantially diminished our level of institutional knowledge and expertise in various agency operational areas.

Despite these administrative obstacles, our study team did complete two of the four sched- uled reviews of common service administrative areas within the agency’s Office of Contracting and Administrative Services (OCAS). The purpose for conducting these evaluations was to determine whether decreased funding and the resulting staff reductions within these offices have had a dramatic impact on their respective servicing abilities in supporting the redefined core functions of the agency. While the services provided by administrative functions are not highly visible outside the agency, the ability of OPM program offices to achieve the primary objectives of the agency are nevertheless closely associated with these internal operations.

The two completed administrative reviews of common services performed by OCAS included various offices within its publishing services division, facilities services

division, and contracting division. The first involved three evaluation areas: (1) the agency issuance process regarding government-wide regulations; (2) delivery of services provided by the agency's health unit; and (3) OPM's publications review process. Additionally, we conducted an evaluation of agency services provided by the OPM resource center, which replaced our agency's full-service library in the fall of 1995, as well as the agency's mail management and contracting services.

Also during this reporting period, the OIG study team conducted an internal review of time and attendance (T&A) procedures performed by OIG timekeepers and our office's time and attendance administrator.

The following are summaries of the above-referenced administrative support service reviews.

OCAS Service Delivery Reviews

During fiscal year 1995, the Office of Personnel Management announced various changes in its organizational structure that altered agency requirements for administrative services. Our study was initiated to determine if resulting reductions in staff and decreased funding for these support services were having or would have an adverse impact on these services to OPM customer groups and organizations, and if these services were being maintained at acceptable levels of efficiency and effectiveness.

Agency regulation issuance system. The agency's issuance system of government-wide regulations follows the requirements set forth in 5 CFR 110.102 for all of its proposed, interim, and final government-wide regulations published in the *Federal Register*.

During the course of our research, we noted that OMB's Regulatory Information Service Center is responsible for government-wide tracking of regulatory modifications and maintains an electronic database of all regulations being written or modified. This database is updated every six months and can be accessed only by authorized users in each federal agency. In OPM, all authorized users are within OCAS's publications management branch (PMB).

We also noted that the Office of the Federal Register requires that submission of documents for publication in the *Federal Register* comply with format and editorial requirements set forth in a government document called the *Document Drafting Handbook* (DDH). In addition, our review revealed that, as of January 1997, this document was available only via the Internet.

All the preceding points were particularly relevant to our review of OPM's regulations issuance system. We conducted this survey to determine if OPM

employees had sufficient guidance to prepare regulations for publication in the *Federal Register*. We learned that the majority of respondents had little or no written internal OPM procedures to follow, while approximately half of these writers had no access to the Internet to retrieve the latest version of the DDH. This point was significant, since many of them only had access to an incomplete or outdated hard-copy version of the handbook. Despite this fact, the respondents indicated they felt they received and continue to receive adequate and timely assistance from the publishing management staff.

As a result of our study, we recommended that all OPM employees who draft proposed, interim or final regulations receive a hard copy of the current DDH now on the Internet. In addition, we recommended that OCAS's PMB provide more comprehensive guidance to OPM on internal editorial, procedural, and clearance matters as they pertain to publication of regulatory changes.

We believe that implementing these recommendations will ensure our agency's continued compliance in the preparation of these regulatory issuances, especially should our agency experience additional loss of institutional knowledge.

Health unit and publishing services: The reviews of the other two areas highlighted in this OCAS study revealed that minimal, yet important, changes in the operational areas of the health unit and publishing services should be made to ensure that their respective customers' needs would continue to be met. For instance, while the majority of the users of the health unit were very satisfied with the services provided by that facility, we recommended that a customer satisfaction survey be performed on a continuing basis to provide the necessary feedback to maintain that high level of satisfaction.

Access to Regulatory Publishing Guidance Limited

OIG Internal Time and Attendance Review

We reviewed the time and attendance procedures and functions currently in place in our office. Though the review necessarily included an examination of the procedures and processes of the agency's entire payroll operation, this report is limited to findings only as they relate to the OIG. Several areas of concern were discovered in both the OIG and the agency's operations. However, the issues discovered in the agency's T&A processing are not discussed in this review, but will be dealt with when and if a decision is made to examine T&A functions in other OPM offices.

The study team made recommendations that would improve the operation of the T&A functions in OIG. To date, all issues have been addressed and every

recommendation implemented.

Other OCAS Administrative Services Studies

The review of service delivery provided by our agency's resource center, mail room, and procurement office was completed during this reporting period and a draft report issued. We anticipate issuing a final report regarding these studies in the near the future. Information on these studies will appear in our next semiannual report.

Our staff is currently dedicating its efforts to other scheduled administrative service reviews within OCAS. These areas relate to building operations and publishing services. A separate report will be issued for each of these services areas. The facilities services study will cover such items as building operations, security services, space and property management, voice telecommunications, and management of our transportation fleet and our warehouse facility in Alexandria, Virginia. The second, regarding publishing services, will focus on publications acquisitions, reproduction and graphics services.

Index of Reporting Requirements (Inspector General Act of 1978, as Amended)

APPENDIX I
Final Reports Issued With Questioned Costs
April 1, 1997 to September 30, 1997

		Number of Reports	Questioned Costs	Unsupported Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	11	$ 29,193,189	$ 0
B.	Reports issued during the reporting period with findings	21	22,277,684	27,100
	Subtotals (A+B)	32	51,470,873	27,100
C.	Reports for which a management decision was made during the reporting period:	26	41,660,023	0
	1. Disallowed costs		32,698,486	0
	2. Costs not disallowed		8,961,537	0
D.	Reports for which no management decision has been made by the end of the reporting period	6	9,810,850	27,100
	Reports for which no management decision has been made within 6 months of issuance	1	2,326,131[1]	0

[1]*Resolution of this item has been postponed at the request of the OIG.*

APPENDIX II
Final Reports Issued With Recommendations for Better Use of Funds
April 1, 1997 to September 30, 1997

	Number of Reports	Dollar Value
No activity during this reporting period	0	$ 0